PITTSFORD SMILES DENTAL PC
GENERAL & SPECIALIZED DENTISTRY

Dental History

Name______________________________ Age_________ How would you rate the condition of your mouth? Excellent Good Fair Poor
How would you rate the condition of your mouth? Excellent Good Fair Poor I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely
Previous Dentist ______________________________ How long have you been a patient?___________Months/Years Referred by_________________________

Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______ **WHAT IS YOUR IMMEDIATE CONCERN?**_________________________________

PERSONAL HISTORY

_____YES _____NO 1.Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____________
_____YES _____NO 2.Have you had an unfavorable dental experience? Please explain: _________________________________
_____YES _____ NO 4.Have you ever had trouble getting numb or had any reactions to local anesthetic? Please explain: ____________________
_____YES _____ NO 5.Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? AGE: ________________
_____YES _____ NO 6.Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?
_____YES _____ NO Please Explain____

GUM AND BONE

_____YES _____ NO 7. Do your gums bleed or are they painful when brushing or flossing? ____
_____YES _____ NO 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? __________________
_____YES _____ NO 9. Have you ever noticed an unpleasant taste or odor in your mouth?
_____YES _____ NO 10. Is there anyone with a history of periodontal disease in your family? ______________________________________
_____YES _____ NO 11. Have you ever experienced gum recession? ____
_____YES ____ NO _12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?
_____YES _____ NO 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?

TOOTH STRUCTURE

_____YES _____ NO 14.Have you had any cavities within the past 3 years?
_____YES _____ NO 15.Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?
_____YES _____ NO 6.Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?
_____YES _____ NO 17.Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?
_____YES _____1 NO 8.Do you have grooves or notches on your teeth near the gum line?
_____YES _____ NO 19.Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?
_____YES _____ NO 20.Do you frequently get food caught between any teeth?

BITE AND JAW JOINT

_____YES _____ NO 21.Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
_____YES _____ NO 22.Do you feel like your lower jaw is being pushed back when you bite your back teeth together?
_____YES _____ NO 23.Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?
_____YES _____ NO 24.In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?
_____YES _____ NO 26.Are your teeth developing spaces or becoming more loose?
_____YES _____ NO 27.Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?
_____YES _____ NO 28.Do you place your tongue between your teeth or close your teeth against your tongue?
_____YES _____ NO 29.Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
_____YES _____ NO 30.Do you clench or grind your teeth together in the daytime or make them sore?
_____YES _____ NO 31.Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?
_____YES ____ NO _32.Do you wear or have you ever worn a bite appliance? ____

SMILE CHARACTERISTICS

_____YES _____ NO 33.Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?________________________
_____YES _____ NO 34.Have you ever whitened (bleached) your teeth? ____
_____YES _____ NO 35.Have you felt uncomfortable or self conscious about the appearance of your teeth? ____
_____YES _____ NO 36.Have you been disappointed with the appearance of previous dental work? ____

____ ____
Patient Signature Date Doctor Signature Date